Littledene Care Services Limited

Littledene House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:
Littledene Care Home is a care home which was providing personal care to 14 older people at the time of the inspection there were 11 people living at the home.

People's experience of using this service:
People's safety was placed at harm because risks were not well managed. Procedures relating to fire safety prevention, infection control, safe staffing levels and risks posed by an unsafe environment, were inadequate and required urgent action in order to ensure people were always safe.

Although staff received training relating to consent, their understanding of the Mental Capacity Act 2005 was inadequate. Records demonstrated that the provider had not always assessed people's capacity to consent to their care and treatment in line with legislation and some records needed review.

Systems designed to monitor the quality and safety of the service were not robust and failed to identify risks. This was of particular concern in relation to good governance and safety.

The administration of medicines requires improvement due to a discrepancy found in relation to PRN (when required) medications.
There were not were enough staff to meet people's needs. Not all staff understood their responsibility to keep people safe from the risk of abuse and knew how to raise concerns.

The service was not clean and infection control procedures were inadequate in ensuring people were protected from the risk of cross infection.

Staff had been provided with basic training but due to individual staff's comprehension of the English language was very limited and their knowledge with regard to keeping people safe was inadequate.

Although people who used the service were provided with a balanced diet, there were no systems in place to support people living with dementia to make an informed choice or preference of food or meals they wished to eat. There were no snacks or drinks available for people to freely access. We have made a recommendation that the registered manager research more innovative ways in how to present soft and pureed meals to people.

People's health needs were monitored in most cases and the provider made referrals to healthcare professionals. However, there are currently two safeguarding investigation being conducted by the local authority with regard to pressure care and moving and handling practices.

Healthcare professional's advice needed to be captured accurately in records so that staff were always clear about people's current needs.

The environment was poorly maintained and placed people at risk of harm. In particular the water temperatures were set at unsafe levels and placed people at risk of harm from scalding and not all window restrictors were in operation. Bedroom doors were ill fitting and some furnishings and fittings were damaged and in a state of disrepair. There were no toilet seats fitted to any of the toilets in the bathrooms or individual toilets. Hand washing facilities were inadequate as some soap dispensers were empty.

Although staff were patient with the people they were supporting there were several examples observed where people's dignity and respect was compromised. This included staff failing to knock on people's bedroom doors before they entered. People on several occasions were referred to by their room number and not their name. Bed linen had been labelled using a black marker pen, with the person's room number written on it. There were no additional aids or prompts within the environment to assist people living with dementia. People were also subjected to the risk of confusion due to the television on at the same time as the radio which was tuned into a Cantonese radio station.

Care plans did not always reflect people's needs when there had been a change. These were also hand written which made some information difficult to read. Care plans were not person centred and not produced in a format that everyone was able to comprehend. There were limited activities to occupy people's time and these did not consider or incorporate people's diverse cultures within the home and also failed to provide activities to support and engage people who were living with dementia. We have made a recommendation regarding specialist training in dementia and behaviour that may challenge.

There is more information is in the full report below.

This was the first inspection since the provider was registered with the Commission in July 2017. The Provider was previously registered the run the service under a different name.

Why we inspected: We received information from the local authority regarding an escalation of concerns about the service; they had been completing monitoring visits. We completed this inspection based on these concerns. At the time of the inspection, we were aware of incidents being investigated by another agency.

Enforcement: The service met the characteristics of Inadequate in three key questions of safe, effective, and well-led and Requires Improvement in caring and responsive. We are taking action and will report on this when it is completed.

Follow up: We will continue to monitor the service closely and discuss ongoing concerns with the local authority. Two safeguarding alerts were raised as a result of this inspection with the local authority.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any
key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our Effective findings below.

Inadequate

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below

Requires Improvement

Is the service well-led?

The service was not well-led

Details are in our Well-led findings below.

Inadequate

Littledene House

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
One inspector and one assistant inspector carried out the inspection visits on 9 May & 15 May 2019.

Service and service type:
Littledene is a care home. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission. The provider was also the registered manager so was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced.

What we did:
We used the information the provider sent us in the Provider Information Return (PIR). This is something providers send to us to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications which relate to significant events the service is required to tell us about.

We gained feedback from the local authority quality monitoring team and spoke with one healthcare professionals and the local safeguarding team. This information helped us to target our inspection activity and highlight where to focus our attention.

During the inspection we spoke with three people who used the service, one relative, three staff members

and the registered manager.

We reviewed three care plans, three medication administration records and looked at two staff files which documented recruitment procedures and ongoing support for staff. We also reviewed rotas, staff training records and other documents relating to the management, safety and quality of the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

- There were inconsistencies regarding the management of the risk of avoidable harm. The registered manager had failed to assess people's risks relating to a variety of issues. These included those related to fire safety, falls, risks associated with hot water temperatures and measures in place for people to access help or assistance in an emergency.
- Care plans did not always document these risks and provided limited guidance for staff to help reduce people's risks. One care plan had identified that a person was at risk of falls. However, there were no updated risk assessments in relation to this person and no specialist equipment used to help prevent them from falling or to ensure staff were alerted at the earliest possible stage i.e. sensory mat.
- The environment placed people at risk of harm. We checked the water temperatures in each of the bedrooms that were occupied and the two bathrooms. We found that these were all excessively high and could place people at risk of harm from scalding. The registered manager was unaware of this issue until we raised it with them. There was no evidence to confirm that water temperatures were monitored or checked regularly.
- Seven out of 11-bedroom doors did not close properly and would be ineffective in the prevention of a fire spreading. The registered manager was unaware of this until this was raised it with them. When we checked the fire records we found that there was no fire drill recorded since the service was registered in July 2017. The fire risk assessment in place had not identified these areas of concern. A referral to the Hertfordshire fire and rescue service was made immediately following this inspection and an urgent visit requested.
- We found that ten out of 11 call bells within people's bedrooms and within the communal bathrooms and toilets areas had been tied up and were inaccessible to people to use in cases of emergency. We found one call bell in a person's bedroom was out of reach and therefore could not be accessed, if they required assistance. This was pointed out to the registered manager immediately, but they were unaware of this practice. The registered manager also informed us that that there were currently 10 people who were living with dementia, and therefore unable to use the call bell system. However, we found that there were no individual risk assessments in place for these people and that night time checks were only carried out every two hours. This meant that people were placed at risk of harm. We also reviewed the accident book and found that there had been six falls recorded since January 2019 three of these falls occurred when people had fallen in their rooms during the night. However, when we checked each person's falls risk assessment none of these records had not been updated and no additional safety measures put in place to protect and safeguard these people from further falls.
- Paint and bleach had been left out in communal areas of the home which could have been accessed by people who used the service and placed them at risk of harm.
- There was limited evidence that confirmed regular safety checks of equipment were in place. We were informed by the manager that health and safety checks were completed annually, with no other checks in place. Such as infection control checks, environmental audits and kitchen safety checks.

The failure to mitigate risks and provide safe care and treatment to service users is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulate Activities) Regulations 2014.

Staffing and recruitment

● Staff told us they felt there were enough staff to meet people's needs. One person told us, "If I need help I go and find someone, and they help me." The registered manager confirmed that there were two people who had been assessed as requiring two staff to support them with all their personal care needs.

● The rota demonstrated that there were currently only two care staff on duty during the day plus the registered manager and one waking night care per night. This meant that when two staff were assisting a person who required two staff, there was only one the registered manager to support the remaining ten people. The registered manager confirmed that one person required the use of a full body hoist and the other person was supported to use a standing hoist. Both people would require two staff to support them when using this equipment.

● At night the waking night staff member had to assist these two people alone. We were also told that these two people required repositioning every two hours during the night time but there was no assessment to show that this could be done safely with one staff member. This placed people at risk of harm.

● Not all staff had the necessary knowledge and understanding to support people effectively due to their limited understanding of English and their limited comprehension of the training provided.

The failure to provide safe levels of staffing at all times is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were placed at risk of harm from staff not understanding how to keep people safe. One staff member we spoke with was also unable to describe the different types of abuse and demonstrated little awareness with regard to the organisations safeguarding policy or procedure to follow in cases of alleged abuse at the home.

● Although the registered manager understood their responsibilities with regard to reporting safeguarding concerns, they had failed to assess staff competencies with regard to their comprehension and knowledge following their safeguarding training.

● We made a safeguarding referral to the local authority which related to all eleven people who lived at the home due to concerns relating to risk, care and welfare.

The failure to ensure service users were effectively safeguarded from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessing risk, safety monitoring and management

Preventing and controlling infection

We found several areas of the home were not clean, this included people's bedrooms and communal areas. We found dirty cleaning cloths left on a radiator to dry, hand dispensers that were empty, open plastic bins in people's bedrooms with discarded and used wipes and a urine stained floor in the toilet on the ground floor.

● Staff had received training in infection control. However, during our inspection, we observed poor infection control practices being carried out. These included a walking frame being moved from the toilet floor and placed straight into an adjacent bath. We observed the floor was then cleaned, and the walking frame placed back onto the toilet floor. We found that there were no paper hand towels available for people to use and two of the hand wash dispensers were empty. People were unable to access toilet rolls in the toilets and bathrooms. We saw that these had been placed out of reach and on a high shelf above each

toilet. These practices place people at risk of cross infection.

Using medicines safely

● Medicines, including controlled drugs, were managed effectively and staff were knowledgeable about the medicines they were administering.

● Staff were aware of the particular requirements of time sensitive medicines and records outlined how medicines should be given to people.

● However, when we carried out a check of people's PRN (when required) medicines we found that one paracetamol tablet was missing from a person dispensing box. This was raised with the registered manager for their immediate attention. The registered manager informed us that there was an annual medication audit, but no other regular audits were in place.

● Staff received training to administer medicines and their practice was observed.

●The manager had adequate recruitment policies and processes in place to ensure that staff were suitable for the role.

● When the service has staff vacancies these are filled with permanent staff doing additional hours and on occasion, reliable agency members of staff. This ensures staff supporting people are consistent.

Learning lessons when things go wrong

● During our inspection we identified issues which had the potential to place people at immediate risk. The provider took steps to address the immediate concerns but had not identified these prior to our inspection.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Where people were at risk of not eating or drinking we found that staff monitored this. However, people did not have free access to drinks and snacks.
- We observed a lunchtime meal being served and found that this appeared to be a more functional experience than a social and relaxed one for people to enjoy. We also heard one staff member using disrespectful language when referring to people who required assistance with their meal. However, we did see that people ate well and appeared to enjoy the food provided and during our second visit we observed one staff member assist a person with their meal in a patient and attentive manner.
- People who we were able to speak with told us that they liked the food provided. One person told us, "It's quite good here and if you don't like what is on the menu they will do you something else." We were informed by the registered manager that care staff prepare the meals as part of the duties and there are no designated kitchen staff. We checked the staff training records which confirmed that staff had received training in food hygiene within the last year. However, we found the pureed meals provided lacked imagination in their presentation and have recommended the registered manager researches alternative methods on how to prepare and present meals for people who require a soft diet or who are living with dementia. This helps to ensure the meals offered provide choice and support people to recognise what the meal consists of with a view to making mealtimes more appealing and enjoyable.
- We saw from the menu that people's cultural diets were respected. However, when we asked one staff member how people who lived with dementia chose the food they would like to eat, we were told "We ask people the week before." This is not good practice meaning people who may have difficulty recalling their choices were unable to make an informed choice about the food they would like to eat that day. Menus were only produced in written format with no pictorial description to prompt people when making a choice. We suggested to the registered manager that pictorial menus would be more appropriate for people who lived with a cognitive impairment, such as dementia.
- People's other healthcare needs were managed, and people had regular access to healthcare professionals with regard to opticians, chiropodists, dentists, GPs and consultants. People's healthcare appointments were monitored. A visiting healthcare professional gave positive feedback saying that the service worked well with them.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● We found that the registered manager and staff had failed to identify when people were restricted unlawfully. For example, the use of locked gate which separated the manager's office from the main hallway and between two bedrooms on the ground floor. This meant that people were unable to freely access the rest of the home. The registered manager had not made the appropriate DoLS applications to the local authority. We raised this with the registered manager, however they did not fully understand the legal requirements to understand why this was an unlawful practice. However, we did find evidence that the registered manager had made application to the local authority with regard to the restrictions placed on people from freely leaving the home.
● Although staff had received MCA training one staff member we spoke with demonstrated a poor understanding of the principles of the MCA and records required reviewing to ensure all decisions relating to people's care were appropriately assessed and taken in their best interests.
● We saw limited information to confirm that people, their relatives or representative had consented to the content of their care plan. The documentation in place with regard to how the service assessed people's capacity to consent did not evidence if the person's capacity to give informed consent had been fully and appropriately assessed prior to the decision being made.

The failure to ensure people's capacity was fully assessed and consent to their care was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The registered manager carried out an assessment of people's needs before they came to live at the service. People's needs were assessed in line with current legislation and a dependency tool established whether the service could meet people's individual needs.

Staff support: induction, training, skills and experience
● Mandatory training was provided to all staff. However, when we spoke with one staff member staff, they were unable to demonstrate to us their knowledge of how to best support and care for people living with dementia and managing people whose behaviour may challenge. We saw the current training programme did not include supporting people whose behaviour may challenge.
● Dementia training was not sufficient to provide staff with sufficient knowledge to support people.
● New staff worked through an induction and worked towards the Care Certificate (a nationally recognised induction standard.) Staff also took part in shadow shifts until they felt ready to work unsupervised. Staff received regular supervision and an annual appraisal. However, the manager had not identified the gaps in staff knowledge.

Adapting service, design, decoration to meet people's needs
● Several areas of the home were in a state of disrepair and unsafe. This included water temperatures within people's bedrooms, the bathrooms and the toilets that were excessively high, damaged and broken furniture within people's bedrooms, bathroom floors were heavily stained with urine, people's bed linen was

substandard, with lumpy pillows and torn sheets. The environment was not dementia friendly and provided no additional prompts, signage or colour schemes that support people living with dementia. People who required support with eating their meals were not provided with any assisted cutlery or crockery to help maintain their independence.

A failure to ensure all areas of the service were safely maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect. Some regulations have not been met.

Ensuring people are well treated and supported; respecting equality and diversity.

● Staff were kind towards people but on several occasions during this inspection we observed staff walk into people's bedrooms without knocking.
● Staff were heard to use language that was institutionalised and disrespectful. For example, they referred to people by their room number and not their name. The registered manager also, on occasions, referred to people's room numbers rather than then person's name.
● We found one person was walking around the home without any footwear on. When we asked the person why this was, they told us they told us that their slippers did not fit. We saw this person had exceptionally long toe nails that had curled underneath their toes and were pushing into their foot. We raised this with the registered manager who said, "(name) had only just moved into the home and I had not had chance to organise a chiropody appointment for them yet." However, when we checked this person admissions date we saw that they had been at the home for a period of three weeks. This placed this person at unnecessary discomfort and also compromised their dignity, health and welfare.

● We saw on one occasion the television was on very loudly in the same communal room as the radio which was tuned into a Cantonese programme. When we expressed our concern with the registered manager that this could lead to confusion and create anxiety for people who were living with dementia, they stated "Well, we normally put the Chinese people in one room and the English ones in the other room." People's choices over where they spent time were not sought.
● Information was detailed within people's care plans with regard to their cultural needs. We were informed that five out of eleven people at the home only spoke Cantonese and one person only spoke Tamil. The registered manager was the only staff member who spoke Cantonese and only one carer understood and spoke Tamil. This meant that people were not able to communicate their needs and wishes when these staff members were not on duty. There were no pictorial communication prompts or boards in people's chosen language and all care plans were written in English. All information displayed throughout the home was only provided in English, not pictorial and not in people's preferred and chosen language.

Respecting and promoting people's privacy, dignity and independence
● People were not always treated with dignity and respect. Although we observed staff ensured people were appropriately dressed and clean there were several occasions where staff were observed to be 'leading and pulling people by the hand, along the corridors. This practice is both disrespectful and belittling. We also witnessed one staff member call out to another, across the communal area of the home when people required assistance to go to the bathroom.

● We saw that people were able to meet privately with their family member if they wanted to.
● We observed staff did not always manage situations effectively where people exhibited behaviour that challenged others and as a result compromised their dignity. For example, one person became agitated with another person who was sitting next to them. All three staff members moved towards the person and restrained them, one staff member was heard to say, "You are naughty for doing that now go and sit down." There were no guidelines within this person's care plan for staff to follow in order to pre-empt these incidents from re-occurring. This practice fails to maintain this persons dignity, self-respect and self-worth. There was also no evidence within this person care plan of any assessment or consideration of a DoLS application with regards to restraint.

A failure to ensure people's dignity and respect was maintained at all times was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
● People were invited to attend monthly resident meetings. We saw a record of a recent meeting that involved a discussion about the current menu choices. One relative told us that the registered manager kept them informed of any changes to their family members care and spoke to them whenever they visited to inform them of how the person was.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Some regulations have not been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice.

● Care plans and risk assessments were reviewed monthly by the registered manager. However, we found some updates and changes to people's needs were not clearly reflected in these records which meant there was a risk of the person not having their needs met. For example, the information about the management of one persons' diabetes was confusing and there was no diabetic care plans in place.

● One relative told us, "Whenever I go to visit (name) the care home manager will take time to talk to me and discuss how (name) has been. We discuss their care and ensure the care plan is up to date and reflects those needs." However, we found limited evidence that people were involved in discussing and reviewing their care plans. Care plans were not always produced in the person's first and preferred language and were not pictorial. This meant that people with a cognitive impairment or where English was not their first language may not be fully able comprehend or be able to agree to the content of their plan of care. The care plans also failed to describe and fully explain people's preferences and choices, for example what time people liked to get up, go to bed or if they preferred a shower or a bath.

● The provider had a limited programme of activities and these were not specific to people's individual interest or hobbies. Also, the activities provided did not incorporate people's cultural interests. The registered manager informed us that there was no designated activity worker and that care staff carried out activities in between their caring duties.

● However due to only two care staff on duty during the daytime we saw that staff had difficulty in finding time to spend quality time with people and offer them meaningful and stimulating activities. During the two-day inspection the only activities were saw being provided were scrabble and staff assisting people with jigsaw puzzles.

● We found that there were no specialised activities provided to support people living with dementia and none of the care staff had attended any specific training that related to providing appropriate activities.

● We also observed long periods of time where people were not occupied in any meaningful way.
On the second day of the inspection an outside entertainer visited the home for a sing a long session. We had to alert the manager to the inappropriate and disrespectful behaviour of the entertainer as this had not been identified as inappropriate by the staff or the manager.

A failure to ensure the care and treatment of service users met their needs and preferences was a breach of Regulation 9 of the Health and Social Care Act. (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

●There was a complaints policy and procedure in place and complaints were managed in line with the provider's own policy and procedure. The complaints procedure was only available in a written format, only in English and not in a pictorial format. This meant that not everyone at the home had the opportunity to access the complaints policy or procedure in a format that they could comprehend.

End of life care and support

- Staff had not received training to help them support people approaching the end of their lives. This was raised with the registered manager at the time of the inspection. However, during the second day of our inspection we were informed that a person had unexpectedly died in hospital and we were able to observe the registered manager worked effectively and sensitively with this person's family at this difficult time and also in partnership with other healthcare professionals.
- Records regarding the care and support people wanted leading up to their death and their wishes following their death were in place.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership,

Management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

- The registered manager did not have a knowledge of current best practice in relation to providing care for people or recognising people's human rights and individuality. The ethos and culture of the service was led by the registered manager so did not reflect recognised good practice guidance.
- We found that the registered manager had limited knowledge with regard to their regulatory requirements and legal responsibilities. In particular their lack of knowledge in relation to the Mental Capacity Act and their responsibility in assessing people's capacity to consent.
- We found widespread concerns and unsafe practices that placed people at risk of harm that had not been recognised by the registered manager.
- The registered manager did not have an effective system to give oversight of risk. Health and safety checks were only carried out on an annual basis, and therefore risks to people had not been identified at the earliest possible stage. This included water temperatures that were excessively high; call bells tied up and out of reach for people to access; stained and damaged furniture; fire doors that did not shut properly; medicine discrepancies; harmful substances left out for people to access and fire records not up to date. We asked the registered manager for audits completed with regard to risks associated with infection control, food safety, medicines and the environmental checks. However, we were informed by the registered manager that they do not currently carry out any audits in relation to these areas of the service. This meant that the manager and staff did not have a good understanding of potential risk and had not taken all possible action to minimise these risks.
- Care plans did not always reflect important information when people's needs changed. Records were not clear which could be confusing for staff. Although individual staff knew people's needs well, information would not easily guide newer staff. This posed a risk of people failing to receive consistent care.
- The manager was not able to provide any evidence that they monitored and reviewed staffing levels in line with people's individual dependency levels, staff's competencies, staff's understanding and knowledge in relation to the training provided. There was no analysis in relation to falls and incidents that occurred at the home in order to reduce this risk of these incidents re-occurring.
- We also found that the manager had a limited understanding of what constitutes a deprivation of a person's liberty due to practices seen as part of this inspection. For example, locked gates that prevented people from accessing all areas of the home freely and without restriction. Staff were observed restraining a person unlawfully and without a DoLS application in place.

●The registered manager told us they did not understand why preventing people from accessing toilet paper and hand towels was not acceptable. We found that the registered manager did not consider marking people's bed linen with a black marker pen and labelled with their room number was both institutionalised and undignified.

Failure to ensure that there were effective systems in place to monitor, review and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they understood what was expected of them and were positive about the registered manager. One staff member commented, "The manager is supportive, and we have a good relationship with each other." The registered manager had a system in place to manage the performance of staff and supervisions were provided on monthly basis.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
●The registered manager was unable to comprehend aspects of the service that were failing and where people's dignity was compromised, their liberty restricted and when people's health and welfare was at risk. The care provided was not person centred and there were several examples of institutionalised practice. .

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Residents' meetings were held every month and gave people the chance to provide feedback and gain information on issues affecting the service. Minutes of these meetings showed that the provider asked for feedback and gave people the chance to raise concerns. The provider also sent out satisfaction surveys, with the most recent being carried out in 2018.
● Minutes of staff meetings demonstrated that they were a two-way process with staff contributions highlighted. They took place regularly and staff were positive about them and found them useful.
● The provider told us that they carried out satisfaction surveys with the people who used the service on an annual basis, but surveys had not yet been sent out for this year. One relative we spoke with told us that they always felt listened to and their feedback was always acted upon.

Continuous learning and improving care
● Where we identified immediate risks to people's safety the registered manager responded promptly. We found the registered manager was open and honest when these concerns were raised with them and accepted the failings and took action such as repairing the fire doors; fitting hot water temperature controls and increasing staffing levels. However, the provider's systems and monitoring had not identified any of these issues.

Working in partnership with others
● Relationships with social care professionals were positive and staff worked well with them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs and did not reflect their preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People did not always receive care and support that maintained their dignity or respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not fully assessed people's capacity to consent to their care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care and treatment people received was unsafe and placed them at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff did not have the necessary knowledge or

	understanding in relation to the home's safeguarding procedures and in recognising the signs of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises was inadequately maintained, unsafe and failed to ensure people were protected from harm and did not provide a comfortable environment in order to maintain people's dignity and privacy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of leadership and governance placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff provided to meet the needs of the people who used the service and to ensure they were kept safe from harm at all times.